

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 004-2028

Facility Name: Alden - North Shore Rehabilitation and Health Care Center, Inc.

Address: 5050 West Touhy Skokie 60077
Number City Zip Code

County: Cook

Telephone Number: (847) 679-6100 Fax # (847) 679-3822

HFS ID Number:

Date of Initial License for Current Owners: 8/6/1999

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☒ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll Telephone Number: (773) 724-6622
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Joan Carl
(Title) Vice-President

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, Inc.

004-2028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less		0	6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	107	2,823	19,002	21,932	8
9	SNF/PED					9
10	ICF	1,128	1,106	86	2,320	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,235	3,929	19,088	24,252	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.44%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO x

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO x

I. On what date did you start providing long term care at this location? Date started 8/14/99

J. Was the facility purchased or leased after January 1, 1978? YES x Date 8/14/99 NO

K. Was the facility certified for Medicare during the reporting year? YES x NO If YES, enter number of beds certified 93 and days of care provided 19,002

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL x MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES x NO

Tax Year: 12/31/11 Fiscal Year: 12/31/11

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden - North Shore Rehabilitation and Health # 004-2028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	604,512	32,504		637,016	1,831	638,847	2,687	641,534			1
2	Food Purchase		334,915		334,915	(38,402)	296,513	(11,827)	284,686			2
3	Housekeeping	165,216	39,903		205,119	1,615	206,734	4,003	210,737			3
4	Laundry	28,316	23,637	17,094	69,047	472	69,519		69,519			4
5	Heat and Other Utilities			231,144	231,144		231,144	145	231,289			5
6	Maintenance	66,396		243,906	310,302	311	310,613	28,804	339,417			6
7	Other (specify):* Related party							4,306	4,306			7
8	TOTAL General Services	864,440	430,959	492,144	1,787,543	(34,173)	1,753,370	28,118	1,781,488			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,394,531	184,569	4,455	2,583,555	19,535	2,603,090	20,559	2,623,649			10
10a	Therapy	139,262	2,875	11,305	153,442		153,442		153,442			10a
11	Activities	98,598	5,107	12,762	116,467		116,467		116,467			11
12	Social Services	46,336			46,336		46,336		46,336			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related party							3,151	3,151			15
16	TOTAL Health Care and Programs	2,678,727	192,551	40,522	2,911,800	19,535	2,931,335	23,710	2,955,045			16
	C. General Administration											
17	Administrative	167,853			167,853		167,853	48,611	216,464			17
18	Directors Fees											18
19	Professional Services			1,026,154	1,026,154	(9,839)	1,016,315	(974,717)	41,598			19
20	Dues, Fees, Subscriptions & Promotions			99,877	99,877		99,877	(87,251)	12,626			20
21	Clerical & General Office Expenses	179,048	33,896	106,465	319,409	365	319,774	179,241	499,015			21
22	Employee Benefits & Payroll Taxes			535,468	535,468	23,835	559,303		559,303			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,463	2,463		2,463	1,401	3,864			24
25	Other Admin. Staff Transportation			2,582	2,582		2,582	8,421	11,003			25
26	Insurance-Prop.Liab.Malpractice			99,104	99,104		99,104	9,626	108,730			26
27	Other (specify):* Related party			21,994	21,994		21,994	3,204	25,198			27
28	TOTAL General Administration	346,901	33,896	1,894,107	2,274,904	14,361	2,289,265	(811,465)	1,477,800			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,890,068	657,406	2,426,773	6,974,247	(277)	6,973,970	(759,637)	6,214,333			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			42,384	42,384		42,384	276,619	319,003			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214,896	214,896		214,896	431,515	646,411			32
33	Real Estate Taxes							450,791	450,791			33
34	Rent-Facility & Grounds			1,149,861	1,149,861		1,149,861	(1,149,861)				34
35	Rent-Equipment & Vehicles			15,451	15,451		15,451	19,405	34,856			35
36	Other (specify):* MIP							62,545	62,545			36
37	TOTAL Ownership			1,422,592	1,422,592		1,422,592	91,014	1,513,606			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,053,717	1,955,416	3,009,133	277	3,009,410	(345,081)	2,664,329			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,053,717	2,006,334	3,060,051	277	3,060,328	(345,081)	2,715,247			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,890,068	1,711,123	5,855,699	11,456,890		11,456,890	(1,013,704)	10,443,186			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Reclassifications - Pages 3 & 4, Column 5

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(38,401.59)	Employee Meals
	22	38,401.59	Employee Meals
22		(14,567.00)	Uniforms
	1	1,831.00	Uniforms
	3	1,615.00	Uniforms
	4	472.00	Uniforms
	6	311.00	Uniforms
	10	9,973.00	Uniforms
	11	0.00	Uniforms
	21	365.00	Uniforms
10		(276.61)	Oxygen - to appropriate cost center
	39	276.61	Oxygen - to appropriate cost center
<u>Others, if any:</u>			
19		(9,839.41)	Clinical Coordinators (Pathway Billing)
	10	9,839.41	Clinical Coordinators (Pathway Billing)
Net		0.00	

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(82)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,216)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(65,940)	30		9
10	Interest and Other Investment Income	(3,467)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,032)	2		13
14	Non-Care Related Interest	(79)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(5,392)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,187)	20		19
20	Contributions	(12,696)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28,032)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,994)	27		24
25	Fund Raising, Advertising and Promotional	(18,115)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(150)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (165,382)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(807,920)	Various	34
35	Other- Attach Schedule	(40,402)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (848,322)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,013,704)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

004-2028

1/1/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (2,239)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(12,289)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	0	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	24,013	6	4
5				5
6	Elim ABC Deprec Exp from Pg 12 series -	(31)	30	6
7				7
8	Valet Cost	(42,952)	21	8
9	Late Fees on Utilities	(1,305)	5	9
10	Late Fee on Telephone	(41)	21	10
11	Other Nursing Income (flu,w/chair, etc)	(1,039)	21	11
12				12
13				13
14	Miscellaneous Income - Misc	(606)	21	14
15	Miscellaneous Income - Medical Records	(988)	10	15
16	Miscellaneous Income - Jury Duty	(172)	21	16
17				17
18	Back Out 30%(2011)of PAC Fees from ILHCA Bills	(1,540)	20	18
19	Back Out Skokie Chamber of Commerce	(320)	20	19
20	Deming Related Costs	(250)	24	20
21				21
22	Back Out Bank Fees - Northshore Associates LLC	(479)	19	22
23	Intercompany Adjustment to correct I/C Interest	(164)	32	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(40,402)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, I # 004-2028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	2,687	0	0	0	0	0	0	0	0	2,687	1
2	Food Purchase	(3,114)	0	0	(8,713)	0	0	0	0	0	0	0	(11,827)	2
3	Housekeeping	0	0	4,003	0	0	0	0	0	0	0	0	4,003	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,305)	0	1,450	0	0	0	0	0	0	0	0	145	5
6	Maintenance	18,797	2,658	7,069	0	0	0	280	0	0	0	0	28,804	6
7	Other (specify):*	0	0	3,833	473	0	0	0	0	0	0	0	4,306	7
8	TOTAL General Services	14,378	2,658	19,042	(8,240)	0	0	280	0	0	0	0	28,118	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(988)	0	20,802	34	711	0	0	0	0	0	0	20,559	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	3,151	0	0	0	0	0	0	0	0	3,151	15
16	TOTAL Health Care and Programs	(988)	0	23,953	34	711	0	0	0	0	0	0	23,710	16
	C. General Administration													
17	Administrative	0	0	48,611	0	0	0	0	0	0	0	0	48,611	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(28,511)	7,891	(954,097)	0	0	0	0	0	0	0	0	(974,717)	19
20	Fees, Subscriptions & Promotions	(34,008)	600	(53,843)	0	0	0	0	0	0	0	0	(87,251)	20
21	Clerical & General Office Expenses	(50,202)	47	130,291	11,087	88,017	0	0	0	0	0	0	179,241	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(250)	0	1,651	0	0	0	0	0	0	0	0	1,401	24
25	Other Admin. Staff Transportation	0	0	8,421	0	0	0	0	0	0	0	0	8,421	25
26	Insurance-Prop.Liab.Malpractice	0	9,551	75	0	0	0	0	0	0	0	0	9,626	26
27	Other (specify):*	(21,994)	0	25,310	1,183	(1,295)	0	0	0	0	0	0	3,204	27
28	TOTAL General Administration	(134,965)	18,089	(793,581)	12,270	86,722	0	0	0	0	0	0	(811,465)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(121,575)	20,747	(750,586)	4,064	87,433	0	280	0	0	0	0	(759,637)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(80,499)	348,931	8,187	0	0	0	0	0	0	0	0	276,619	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,710)	429,073	3,470	0	2,682	0	0	0	0	0	0	431,515	32
33	Real Estate Taxes	0	447,032	2,601	0	1,158	0	0	0	0	0	0	450,791	33
34	Rent-Facility & Grounds	0	(1,149,861)	0	0	0	0	0	0	0	0	0	(1,149,861)	34
35	Rent-Equipment & Vehicles	0	0	19,405	0	0	0	0	0	0	0	0	19,405	35
36	Other (specify):*	0	62,545	0	0	0	0	0	0	0	0	0	62,545	36
37	TOTAL Ownership	(84,209)	137,720	33,663	0	3,840	0	0	0	0	0	0	91,014	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(26,265)	(247,517)	(71,299)	0	0	0	0	0	(345,081)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(26,265)	(247,517)	(71,299)	0	0	0	0	0	(345,081)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(205,784)	158,467	(716,923)	(22,201)	(156,244)	(71,299)	280	0	0	0	0	(1,013,704)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group, Ltd.		See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,149,861	North Shore Touhy Associates LLC		\$	\$ (1,149,861)	1
2	V	32	Interest Income-Repl Reserve/Misc	161,516	North Shore Touhy Associates LLC			(161,516)	2
3	V	6	R & M - Replacement Reserves		North Shore Touhy Associates LLC		2,658	2,658	3
4	V	19	Accounting Fees/Bank Charges		North Shore Touhy Associates LLC		7,891	7,891	4
5	V	21	Licenses & Inspections		North Shore Touhy Associates LLC		47	47	5
6	V	20	Dues & Subscriptions		North Shore Touhy Associates LLC		600	600	6
7	V	33	Real Estate Tax Expense		North Shore Touhy Associates LLC		447,032	447,032	7
8	V	26	Property & Liability Insurance		North Shore Touhy Associates LLC		9,551	9,551	8
9	V	36	Mortgage Insurance Premium		North Shore Touhy Associates LLC		62,545	62,545	9
10	V	32	Interest - Other/Amortization		North Shore Touhy Associates LLC		590,589	590,589	10
11	V	30	Depreciation Expense		North Shore Touhy Associates LLC		348,931	348,931	11
12	V								12
13	V								13
14	Total			\$ 1,311,377			\$ 1,469,844	\$ * 158,467	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, Inc.# 004-2028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 1,450	\$ 1,450 15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		1,651	1,651 16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		8,421	8,421 17
18	V	26 Insurance		Alden Management Services, Inc.		75	75 18
19	V	20 Dues/Subscriptions	54,882	Alden Management Services, Inc.		1,039	(53,843) 19
20	V	30 Depreciation		Alden Management Services, Inc.		8,187	8,187 20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		2,601	2,601 21
22	V	35 Rent-Equip/Vehicles		Alden Management Services, Inc.		19,405	19,405 22
23	V	32 Interest		Alden Management Services, Inc.		3,470	3,470 23
24	V	1 Dietary Aide Coordinator Salary		Alden Management Services, Inc.		2,687	2,687 24
25	V	3 Housekeeping Coordinator Salary		Alden Management Services, Inc.		4,003	4,003 25
26	V	7 Employee Benef % -Gen'l Servs		Alden Management Services, Inc.		3,833	3,833 26
27	V	10 Nurs/Med Records Salary		Alden Management Services, Inc.		20,802	20,802 27
28	V	15 Employee Benef % - Health Care		Alden Management Services, Inc.		3,151	3,151 28
29	V	17 Administrative Salary		Alden Management Services, Inc.		48,611	48,611 29
30	V	27 Employee Benef %-Administrative		Alden Management Services, Inc.		25,310	25,310 30
31	V	19 Professional Fees	975,235	Alden Management Services, Inc.		21,138	(954,097) 31
32	V	21 Gen'l & Admin		Alden Management Services, Inc.		130,291	130,291 32
33	V	6 Repairs & Maintenance	17,699	Alden Management Services, Inc.		24,768	7,069 33
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,047,816			\$ 330,893	\$ * (716,923) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Tube Feeding	\$ 14,071	Prism Health Care Services, Inc.	0.00%	\$ 5,358	\$ (8,713)	15
16	V	10	Equipment Rental	6,660	Prism Health Care Services, Inc.		6,694	34	16
17	V	39	Ancillary Services	40,845	Prism Health Care Services, Inc.		14,580	(26,265)	17
18	V	21	Gen'l & Admin Salary		Prism Health Care Services, Inc.		7,092	7,092	18
19	V	27	Employee Benefits		Prism Health Care Services, Inc.		1,183	1,183	19
20	V	7	Employee Benefits		Prism Health Care Services, Inc.		473	473	20
21	V	21	Gen'l & Admin		Prism Health Care Services, Inc.		3,995	3,995	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 61,576			\$ 39,375	\$ * (22,201)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	\$ 500,181	Forum Extended Care Services II, Inc.	0.00%	\$ 693,164	\$ 192,983	15
16	V	39	I.V.	499,137	Forum Extended Care Services II, Inc.		58,676	(440,461)	16
17	V	39	Wound Care	189	Forum Extended Care Services II, Inc.		150	(39)	17
18	V	10	House Stock	12,849	Forum Extended Care Services II, Inc.		11,889	(960)	18
19	V	10	Pharmacy Consultant	2,233	Forum Extended Care Services II, Inc.		3,904	1,671	19
20	V	27	Employee Vaccinations	6,186	Forum Extended Care Services II, Inc.		4,891	(1,295)	20
21	V	21	Employee Benefit: G & A		Forum Extended Care Services II, Inc.		6,401	6,401	21
22	V	21	Salary: G & A		Forum Extended Care Services II, Inc.		51,417	51,417	22
23	V	21	General & Administrative		Forum Extended Care Services II, Inc.		30,199	30,199	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		2,682	2,682	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		1,158	1,158	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,020,775			\$ 864,531	\$ * (156,244)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Revenue	\$ 1,904,422	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,833,123	\$ (71,299)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,904,422			\$ 1,833,123	\$ * (71,299)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$ 35,984	Alden Bennett Construction Company, Inc.	0.00%	\$ 36,264	\$ 280	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 35,984			\$ 36,264	\$ * 280	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, Inc. # 004-2028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Home Office rental	2
3			Alden-Long Grove Rehabilitation and Health Ca	Long Grove				3
4			Alden-Lincoln Park Rehabilitation and Health C	Chicago	Forum Extended Care Se	Chicago	Pharmacy	4
5			Alden-Northmoor Rehabilitation and Health Car	Chicago	Alden Management Serv	Chicago	Management	5
6			Alden-Lakeland Rehabilitation and Health Care (	Chicago				6
7			Alden of Old Town East, Inc.	Bloomingtondale	Alden Gardens of Bloom	Bloomingtondale	Supportive Living Fac	7
8			Alden Terrace of McHenry Rehabilitation and He	McHenry	Alden Garden Courts of	DesPlaines	Assisted Living/Alzhei	8
9			Alden - Wentworth Rehabilitation and Health Ca	Chicago	Alden Courts of Waterfo	Aurora	Alzheimers Facility	9
10			Alden Estates of Naperville, Inc.	Naperville	Alden Gardens of Water	Aurora	Assisted Living	10
11			Alden - Valley Ridge Rehabilitation and Health C	Bloomingtondale	Prism Health Care Servi	Schaumburg	Nursing and Durable	11
12			Alden Village Health Facility for Children and Yo	Bloomingtondale	Community Physical The	Addison	Therapy Provider	12
13			Alden - Orland Park Rehabilitation and Health C	Orland Park	Alden Bennett Construct	Chicago	General Contractor	13
14			Alden - Princeton Rehabilitation and Health Car	Chicago	Fort Medical Equipment	Fort Atkinson, WI	Nursing and Durable	14
15			Alden of Old Town West, Inc.	Bloomingtondale	Fort Healthcare, LLC	Fort Atkinson, WI	SNF w/in hospital	15
16			Alden - Town Manor Rehabilitation and Health C	Cicero				16
17			Alden Trails, Inc.	Bloomingtondale				17
18			Alden - Poplar Creek Rehabilitation and Health (	Hoffman Estates				18
19			Alden - Des Plaines Rehabilitation and Health C	Des Plaines				19
20			Alden Estates of Evanston, Inc.	Evanston				20
21			Alden - Alma Nelson Manor, Inc.	Rockford				21
22			Alden - Park Strathmoor, Inc.	Rockford				22
23			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				23
24			Alden Estates of Barrington, Inc.	Barrington				24
25			Alden of Waterford, LLC	Aurora				25
26			Alden Springs, Inc.	Bloomingtondale				26
27			Alden Village North, Inc.	Chicago				27
28			Alden Estates of Skokie, Inc.	Skokie				28
29			Alden Estates of Countryside, Inc.	Jefferson, WI				29
30								30

Facility Name & ID Number Alden - North Shore Rehabilitation and Health # 004-2028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President	CEO	100.00	181,589	0.736	1.84	Salary	\$ 3,411	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	67,374	0.736	1.84	Salary	1,266	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,791	0.736	1.84	Salary	729	6-7	3
4											4
5											5
6											6
7	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										8
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers.										9
10											10
11											11
12											12
13								TOTAL	\$ 5,406		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, # 004-2028 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Alden Management Services, Inc.
Street Address 4200 W. Peterson
City / State / Zip Code Chicago, IL 60646
Phone Number (773-724-6622
Fax Number (773-724-6622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Patient Days	1,315,389	34	\$ 78,619	\$	24,252	\$ 1,450	1
2	24	Travel/Seminar	Patient Days	1,315,389	34	89,570		24,252	1,651	2
3	25	Other Admin Travel	Patient Days	1,315,389	34	456,762		24,252	8,421	3
4	26	Insurance	Patient Days	1,315,389	34	4,082		24,252	75	4
5	20	Dues/Subscriptions	Patient Days	1,315,389	34	56,361		24,252	1,039	5
6	30	Depreciation	No. of Providers	34	34	291,758		1	8,187	6
7	33	Real Estate Tax	Patient Days	1,315,389	34	156,401		24,252	2,601	7
8	35	Rent-Equip & Vehicles	Patient Days	1,315,389	34	1,052,493		24,252	19,405	8
9	32	Interest	Patient Days	1,315,389	34	1,368,621		24,252	3,470	9
10	1	Dietary Salary	Patient Days	1,315,389	34	145,718	145,718	24,252	2,687	10
11	3	Housekeeping Salary	Patient Days	1,315,389	34	217,102	217,102	24,252	4,003	11
12	7	Employee Benef-Gen'l Servs	Patient Days	1,315,389	34	207,899		24,252	3,833	12
13	10	Nurs/Med Records Salary	Patient Days	1,315,389	34	1,184,449	1,184,449	24,252	20,802	13
14	15	Employee Benef-Health Care	Patient Days	1,315,389	34	170,963		24,252	3,151	14
15	17	Administrative Salary	Patient Days	1,315,389	34	2,886,253	2,886,253	24,252	48,611	15
16	27	Employee Benef-Administrative	Patient Days	1,315,389	34	1,372,783		24,252	25,310	16
17	19	Professional Fees	Patient Days	1,315,389	34	1,146,467	654,108	24,252	21,138	17
18	21	Gen'l & Administrative	Patient Days	1,315,389	34	7,066,809	5,970,419	24,252	130,291	18
19	6	Repairs & Maintenance	Patient Days	1,315,389	34	1,343,350	1,077,524	24,252	24,768	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 19,296,460	\$ 12,135,573		\$ 330,893	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge (GL 2505/7053/7059)		X	Mortgage	\$42,694.00	08/01/05	\$ 8,388,000	\$ 7,940,873	07/31/2045	5.4000	\$ 419,031	1
2	Cambridge(GL 2505-183/7053/7059)		X	Operating Loss Loan	\$16,822.00	08/01/03	2,853,922	2,813,405	08/31/2039	5.6900	161,342	2
3	Bank Leumi (GL 2503/7035)		X	LOC		10/23/10	1,103,270	1,103,270	07/02/12	5.0000	52,366	3
4	Amortization-Fin/Refin Fee		X	Working Capital							10,216	4
5	Insurance Interest (GL 7053)		X	Medical Malpractice							1,109	5
	Working Capital											
6	Related party-AMS		x	Working Capital							3,470	6
7	Related party-FECH		x	Working Capital							2,682	7
8												8
9	TOTAL Facility Related				\$59,516.00		\$ 12,345,192	\$ 11,857,548			\$ 650,216	9
	B. Non-Facility Related*											
10	Interest Income Repl Reserve		X								(337)	10
11	Interest Income(4646/4975)		X								(3,467)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (3,804)	14
15	TOTALS (line 9+line14)						\$ 12,345,192	\$ 11,857,548			\$ 646,411	15

16)

Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ 62,545

Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	316,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	376,132	2
3. Under or (over) accrual (line 2 minus line 1).			\$	59,632	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	387,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	447,032	7
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax	\$	3,759	
Real Estate Tax Bill for Calendar Year:			\$	450,791	
2006	228,436	8	FOR BHF USE ONLY		
2007	253,072	9	13	FROM R. E. TAX STATEMENT FOR 2010 \$	13
2008	260,044	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
2009	307,288	11	15	LESS REFUND FROM LINE 6 \$	15
2010	376,132	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
The current year accrual is based on an estimated 3% increase of the prior year tax.					

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden - North Shore Rehabilitation and Health Care Center, Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 004-2028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 724-6622 FAX #: (773)-283-3997

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>See attached supplement</u>	<u>Related Party-Alden Management Ser</u>	\$ <u>300,377.00</u>	\$ <u>2,601.00</u>
2.	<u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	\$ <u>42,023.00</u>	\$ <u>1,158.00</u>
3.	<u>10-28-429-015-0000</u>	<u>Nursing Home Facility</u>	\$ <u>2,432.10</u>	\$ <u>2,432.10</u>
4.	<u>10-28-429-016-0000</u>	<u>Nursing Home Facility</u>	\$ <u>1,795.66</u>	\$ <u>1,795.66</u>
5.	<u>10-28-429-017-0000</u>	<u>Nursing Home Facility</u>	\$ <u>8,919.40</u>	\$ <u>8,919.40</u>
6.	<u>10-28-429-018-0000</u>	<u>Nursing Home Facility</u>	\$ <u>37,209.91</u>	\$ <u>37,209.91</u>
7.	<u>10-28-429-019-0000</u>	<u>Nursing Home Facility</u>	\$ <u>37,226.16</u>	\$ <u>37,226.16</u>
8.	<u>10-28-429-020-0000</u>	<u>Nursing Home Facility</u>	\$ <u>36,993.54</u>	\$ <u>36,993.54</u>
9.	<u>10-28-429-021-0000</u>	<u>Nursing Home Facility</u>	\$ <u>36,993.54</u>	\$ <u>36,993.54</u>
10.	<u>10-28-429-022-0000</u>	<u>Nursing Home Facility</u>	\$ <u>36,964.96</u>	\$ <u>36,964.96</u>
TOTALS			\$ <u><u>540,935.27</u></u>	\$ <u><u>202,294.27</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Alden - North Shore Rehabilitation and Health Care Center, Inc</u>	COUNTY	<u>Cook</u>
---------------	---	--------	-------------

FACILITY IDPH LICENSE NUMBER 004-2028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 724-6622 FAX #: (773-283-3997

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-28-429-023-0000</u>	<u>Nursing Home Facility</u>	\$ <u>36,935.64</u>	\$ <u>36,935.64</u>
2. <u>10-28-429-024-0000</u>	<u>Nursing Home Facility</u>	\$ <u>36,911.06</u>	\$ <u>36,911.06</u>
3. <u>10-28-429-025-0000</u>	<u>Nursing Home Facility</u>	\$ <u>36,911.06</u>	\$ <u>36,911.06</u>
4. <u>10-28-429-026-0000</u>	<u>Nursing Home Facility</u>	\$ <u>36,911.06</u>	\$ <u>36,911.06</u>
5. <u>10-28-429-027-0000</u>	<u>Nursing Home Facility</u>	\$ <u>29,863.10</u>	\$ <u>29,863.10</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>177,531.92</u>	\$ <u>177,531.92</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,208

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

 YES

☒

 NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing facility/SNF	34,483	1997	\$ 955,797	1
2					2
3	TOTALS	34,483		\$ 955,797	3

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1999	1999	6,782,967	203,542	40	169,574	(33,968)	2,034,888	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	draper corp-electric screen			1999	1,252		10			1,252	9
10	dakota wiring & comm.-wiring for cable tv			1999	2,500		10			2,500	10
11	climate serv-repair compressor			1999	1,990	133	15	133		1,604	11
12	tci cable-install cable			1999	1,254		10			1,254	12
13	ABC-install tiles/repair			2000	4,011	267	15	267		3,162	13
14	ABC-mainten-various/construction			2000	5,000		10			5,000	14
15	ABC-mainten-various/construction			2000	10,000		10			10,000	15
16	ABC-mainten-various/construction			2000	10,000		10			10,000	16
17	new horizons-phone system			2000	5,744		10			5,744	17
18	new horizons-phone system & cable			2000	2,784		10			2,784	18
19	new horizons-phone system			2000	3,742		10			3,742	19
20	dbs contract.-lawn sprinkler system			2000	1,611	107	15	107		1,233	20
21	ABC-misc construction work			2000	5,347		5			5,347	21
22	ABC-misc construction work			2000	13,118		5			13,118	22
23											23
24	ABC-misc construction work (12/31/01 finished-begin exp '02)			2001	3,361	337	10	337		3,361	24
25	Laport (walk off mat carpet/floor covering)			2001	3,548		5			3,548	25
26	The Floor Source (PT carpet/floor covering)			2001	1,576		5			1,576	26
27	ABC-beds/bedside cabinets/washers/dryers/bookcases/wallcover			2001	289,721	19,315	15	19,315		212,464	27
28	New Horizon (phone system)			2001	1,256	94	10	94		1,256	28
29											29
30	ABC-misc construction work			2002	16,368	1,091	15	1,091		10,911	30
31											31
32	ABC-misc construction work			2003	2,116	212	10	212		2,116	32
33	GT Mechanical-repair exhaust fans			2003	6,080	608	10	608		5,269	33
34	EWS-repair opxyen alarm ssytem			2003	2,054		5			2,054	34
35	ABC-parking lot upgrades			2003	7,538	754	10	754		6,407	35
36	ABC-parking lot repairs			2003	2,943		5			2,943	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, Inc.

004-2028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	GT Mechanical-thermostat equip	2004	\$ 1,693	\$ 169	10	\$ 169	\$	\$ 1,354	37
38	ABC-repair sewer	2004	19,580	1,958	10	1,958		15,175	38
39	GT Mechanical-misc repairs	2004	1,442		5			1,442	39
40	GT Mechanical-replace pump	2004	2,496		5			2,496	40
41	GT Mechanical-misc repairs	2004	614		5			614	41
42	ABC-bath,plumb. Upgrade	2004	1,813	181	10	181		1,373	42
43	ABC-painting supplies	2004	1,258		5			1,258	43
44	GT Mechanical-Electric improvement	2004	917	92	10	92		674	44
45	ABC-plumbing/misc. repairs	2004	3,971	397	10	397		2,878	45
46	TopNotch-motor drive repair	2004	3,139	314	10	314		2,224	46
47	ABD- carpet repairs	2004	4,943	494	10	494		3,500	47
48	ABC-misc repairs	2004	2,783	99	7	99		2,783	48
49	ABC parking lot improve.	2004	16,008	1,601	10	1,601		11,607	49
50									50
51	ABC-Cabinetry	2005	4,393	220	15	220		1,501	51
52	Patten CAT-Repair Generator	2005	2,074	104	20	104		701	52
53	GT Mechanical-No AC Water/Temp Low	2005	1,340	134	10	134		759	53
54	seal/crack/fill asphalt (LLC)	2005	6,045	756	8	756		4,913	54
55	Installed new alerton controllrs/rewire/cycling relay	2005	7,064	706	10	706		4,862	55
56	tile and grout restoration-all ceramic tile floors	2005	7,830	783	10	783		5,089	56
57	replaced leaky ceiling parts	2005	1,480		5			1,480	57
58	fabricate/install elevator finishes/baseboards/etc.	2005	12,843	1,284	10	1,284		8,347	58
59	new hvac motor	2005	3,860	386	10	386		2,348	59
60	wired new electronic starter	2005	1,530	153	10	153		931	60
61									61
62	GT Mechanical - New Motors/brackets/fan blades	2007	4,497	899	5	899		4,497	62
63	ABC/Patten - Replace/Repair Generator	2007	2,898	290	10	290		1,449	63
64	Second Floor Nurses Station	2007	4,246	425	10	425		2,123	64
65	Repair Condensor/Fan Motor sensors	2007	2,529	506	5	506		2,276	65
66	Replaced Domestic Water Pump-ABC	2007	3,032	303	10	303		1,263	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,314,197	\$ 238,712		\$ 204,744	\$ (33,968)	\$ 2,443,452	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, Inc.

004-2028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,314,197	\$ 238,712		\$ 204,744	\$ (33,968)	\$ 2,443,452	1
2	Repaired AC	2008	7,776	778	10	778		2,722	2
3	New Asphalt - ABC	2008	2,973	372	8	372		1,177	3
4	New Asphalt - ABC	2008	4,110	514	8	514		1,627	4
5	New Fire Alarm Printer/New Ceiling Tiles-ABC	2008	4,007	401	10	401		1,269	5
6	New Plumbing and Electrical Fixtures-ABC	2008	2,509	167	15	167		641	6
7	New Clear Acrylic-Oakton Glass&Mirror	2008	3,517	352	10	352		1,055	7
8	General Labor for Atrium-AMS Maintenance Allocation	2008	3,741	748	5	748		2,245	8
9	Repair Water Heater	2008	3,237	324	10	324		1,214	9
10									10
11	ABC - New Fire Alarm Annunciator	2009	2,637	264	10	264		615	11
12	ABC-New Carpeting ,New Overload Starter&Phase Motor Starter	2009	4,340	868	5	868		2,025	12
13	GT Mechanical-New Belts,New Starter&Coils for Chiller Pump	2009	4,602	460	10	460		1,074	13
14	GT Mechanical-New Pump Seals	2009	3,308	331	10	331		772	14
15									15
16	ABC - Exhaust Vent Shaft	2010	3,539	354	10	354		383	16
17	ABC- Concrete Driveway Sealcoat	2010	18,600	1,240	15	1,240		1,343	17
18	TOPNOT - Boiler Assembly - Kitchen Equipment	2010	3,018	604	5	604		654	18
19									19
20	Columns, Masonry at Handicapped Parking Area - ALDBEN	2011	2,959	543	5	543		543	20
21	Upholstry: Fabric Chairs - Shades Window Sunscreen-ALDDES	2011	9,984	499	5	499		499	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,399,054	\$ 247,529		\$ 213,561	\$ (33,968)	\$ 2,463,309	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, Inc.

004-2028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,399,054	\$ 247,529		\$ 213,561	\$ (33,968)	\$ 2,463,309	1
2	Forum Prof Ctr: Remodeling	1979	13,418		20			13,418	2
3	Forum Prof Ctr: Build Improv - multiple	1980	26,131		15			26,131	3
4	Forum Prof Ctr: Tennant Improv	1986	824		13			824	4
5	Forum Prof Ctr: AMS remodel	1990	5,604		10			5,604	5
6	Forum Prof Ctr: Roof	1994	2,956		16			2,956	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,042	65	16	65		1,039	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,646	13	10	13		1,605	8
9	Forum Prof Ctr: Remodel/electrical	2001	641	24	7	24		595	9
10	Forum Prof Ctr: bathroom remodel	2002	567	53	5	53		527	10
11	Forum Prof Ctr: remodel suites/etc.	2003	729	74	9	74		657	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,245	104	7	104		1,954	12
13	Forum Prof Ctr: Suite renovation	2005	453	27	10	27		537	13
14	Forum Prof Ctr: Superior installations, etc.	2006	108	3	4	3		108	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	435	68	7	68		294	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	374	54	7	54		208	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	761	73	7	73		162	17
18	Forum Prof Ctr: Building Renovations	2010	1,296	263	7	263		340	18
19	Forum Prof Ctr: Building Renovations	2011	5,684	137	7	137		137	19
20	Alden Mgt Servs: Remodel suites	1993	6,963		7			6,963	20
21	Alden Mgt Servs: Remodel suites	2002	290		7			290	21
22	Alden Mgt Servs: Remodel suites	2003	6,295		7			6,295	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	Adjust for ABC Related Party Profit	2008	(204)	(12)		(12)		(48)	30
31	Adjust for ABC Related Party Profit	2009	(92)	(15)		(15)		(45)	31
32	Adjust for ABC Related Party Profit	2010	(271)	(8)		(8)		(17)	32
33	Adjust for ABC Related Party Profit	2011	23	4		4		4	33
34	TOTAL (lines 1 thru 33)		\$ 7,476,973	\$ 248,456		\$ 214,488	\$ (33,968)	\$ 2,533,848	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$868,349	\$123,246	\$91,274	\$(31,972)		\$654,505	71
72	Current Year Purchases	415,586	12,899	12,899			12,242	72
73	Fully Depreciated Assets	132,669	343	343			132,670	73
74								74
75	TOTALS	\$1,416,604	\$136,488	\$104,516	\$(31,972)		\$799,417	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party - AMS	Various	98 - '02	\$4,026	\$	\$	\$	3	\$4,026	76
77										77
78										78
79										79
80	TOTALS			\$4,026	\$	\$	\$		\$4,026	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,853,399	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$384,943	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$319,003	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(65,940)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,337,291	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Conservatory Project	\$227,849	92
93			93
94			94
95		\$227,849	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Related Party - Cost is backed Out
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES

XNO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy:

YES

XNO

Terms:*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES

XNO
16. Rental Amount for movable equipment: \$15,701Description:Copy mach gl 6861, postage meter gl 6850, & office equip gl 6859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	related party- Pg 6A	various	\$ #####	\$ 13,181	17
18					18
19	Auto lease GL 6890	various	0.00		19
20					20
21	TOTAL		\$ #####	\$ 13,181	21

10. Effective dates of current rental agreement:

Beginning3/1/2000

Ending12/31/2029

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$Varies
13.	/2013	\$Varies
14.	/2014	\$Varies

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nursing on site

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 778,325	\$		\$ 778,325	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			52,738			52,738	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			1,073,359			1,073,359	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				693,164		693,164	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-1,39-3, if any								12
13	Other (specify): See Pg 16A					(71,299)	138,042		66,743	13
14	TOTAL			\$		\$ 1,833,123	\$ 831,206		\$ 2,664,329	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

XIV. Special Services (Direct Cost)

Page 16
Col 5: PT,OT, &
Col 6: Supplies

Line	Service	Col. 1:	Ref. No.	To Pg 16:	Col. No.		
1.	OT		39-3	To Col 5		\$0.00	\$778,324.58
2.	ST		39-3	To Col 5		0.00	52,737.70
3.							
4.	PT		39-3	To Col 5		0.00	1,073,359.28
5.							
6.							
7.							
8.							
	Pharmacy Supplies per GL					0.00	500,180.96
	Manual Input from Related Party- Forum Drugs						192,983.00
9.	Total to line 9 Pharmacy	See Pg 16A		To Col 6		0.00	693,163.96
10.							
11.							
12.	Exceptional Care-Salaries:	See pg 16A		To Col. 3		0.00	0.00
12.	Exceptional Care-Supplies:	See pg 16A		To Col. 6		0.00	0.00
	Total Exceptional Care (Line 12, Col 8)					0.00	0.00
13.	Other:	See Pg 16A					
13.	Col 5: Manual Input: Related Party - CPT			To Col 5			(71,299.00)
	Other					0.00	604,530.59
	Manual Input: Related Party - Prism						(26,265.00)
	Manual Input: Related Party FECII - I.V.						(440,461.00)
	Manual Input: Related Party FECII - Wound Care						(39.00)
	Oxygen, from reclass worksheet (Pg 4A)						276.61
13.	Col 6: Supplies Total			To Col 6		0.00	138,042.20
13.	Total Line 13, Column 8					0.00	66,743.20
14.	Total					0.00	2,664,328.72

ST

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, I# 004-2028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 416	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>25,000</u>)	1,232,301	1,232,301	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		44,226	6
7	Other Prepaid Expenses	7,233	7,233	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	34,809	210,154	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,274,343	\$ 1,494,330	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		955,797	13
14	Buildings, at Historical Cost		7,878,133	14
15	Leasehold Improvements, at Historical Cost	503,345	511,790	15
16	Equipment, at Historical Cost	270,777	1,847,153	16
17	Accumulated Depreciation (book methods)	(536,247)	(3,974,188)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		161,026	21
22	Other Long-Term Assets (spe <u>CIP, S/holders</u>	18,866	432,304	22
23	Other(specify): <u>Due from affiliates</u>	6,873,502	9,657,365	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,130,243	\$ 17,469,378	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,404,586	\$ 18,963,708	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 679,306	\$ 683,555	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,280	40,280	28
29	Short-Term Notes Payable	1,103,270	1,231,767	29
30	Accrued Salaries Payable	325,248	325,248	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,888	54,888	31
32	Accrued Real Estate Taxes(Sch.IX-B)		387,400	32
33	Accrued Interest Payable	14,594	63,668	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr Exp,Due HFS,SalesTax,Etc.</u>	11,135	186,698	36
37	<u>Due to affiliates</u>	2,164,683	2,002,265	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,393,404	\$ 4,975,769	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,770,522	39
40	Mortgage Payable		7,855,259	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to affiliates</u>			43
44	<u>S/holder loans, others</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,625,781	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,393,404	\$ 15,601,551	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,011,182	\$ 3,362,157	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,404,586	\$ 18,963,708	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,886,431	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,886,431	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,124,751	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,124,751	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,011,182	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care # 004-2028 Report Period Beginning: 1/1/2011

Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,558,915	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,558,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,220	6
7	Oxygen	317	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 10,537	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	186	12
13	Barber and Beauty Care	808	13
14	Non-Patient Meals	82	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,466	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,107	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,649	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,467	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,467	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Pg 19A	3,072	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,072	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,581,641	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,787,543	31
32	Health Care	2,911,800	32
33	General Administration	2,274,904	33
	B. Capital Expense		
34	Ownership	1,422,592	34
	C. Ancillary Expense		
35	Special Cost Centers	3,009,133	35
36	Provider Participation Fee	50,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,456,890	40
41	Income before Income Taxes (line 30 minus line 40)**	1,124,751	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,124,751	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden - North Shore Rehabilitation and H # 001-7319 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Miscellaneous Income/Medical Records	988
Miscellaneous Income/Garnishment	106
Miscellaneous Income/Jury Duty Receipt	172
Miscellaneous Income/Refund	500
Gain on Sale of Assets	1,306
Line 28 Total:	<u>3,072</u>

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,611	2,611	\$ 106,822	\$ 40.91	1
2	Assistant Director of Nursing	1,735	1,735	78,404	45.19	2
3	Registered Nurses	31,426	33,696	1,145,216	33.99	3
4	Licensed Practical Nurses	3,937	4,191	105,073	25.07	4
5	CNAs & Orderlies	51,383	54,384	769,099	14.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,771	2,984	59,568	19.96	8
9	Activity Director	2,160	2,365	44,204	18.69	9
10	Activity Assistants	5,144	5,393	54,395	10.09	10
11	Social Service Workers	1,960	2,108	46,336	21.98	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	50,849	24.45	13
14	Head Cook	6,232	6,240	119,493	19.15	14
15	Cook Helpers/Assistants	32,757	34,953	434,170	12.42	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	66,397	31.92	17
18	Housekeepers	13,384	14,802	165,216	11.16	18
19	Laundry	2,433	2,624	28,316	10.79	19
20	Administrator	2,080	2,080	115,642	55.60	20
21	Assistant Administrator	1,840	1,840	52,211	28.38	21
22	Other Administrative	7,075	7,253	199,471	27.50	22
23	Office Manager	2,136	2,136	32,920	15.41	23
24	Clerical	2,753	2,895	26,350	9.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,950	3,150	112,695	35.78	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	981	998	12,489	12.51	31
32	Other Health Care Unit Manager	3,518	3,534	48,220	13.64	32
33	Other(specify) Unit Secretary	952	952	16,512	17.34	33
34	TOTAL (lines 1 - 33)	186,378	197,084	\$ 3,890,068 *	\$ 19.74	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$	1-3	35
36	Medical Director	Monthly	12,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,232	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,677	11-3	44
45	Social Service Consultant	Monthly	280	11-3	45
46	Other(specify) Psycho-Social Consul	Monthly	280	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,469		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number		Alden - North Shore Rehabilitation and Health Care C		STATE OF ILLINOIS		Page 21		
				# 004-2028		Report Period Beginning: 1/1/2011		
						Ending: 12/31/2011		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Illarde	Administrator	0	\$ 115,590	Workers' Compensation Insurance	\$ 78,217	IDPH License Fee	\$	
Cynthia Palao	Assistant Administrator	0	52,263	Unemployment Compensation Insurance	24,424	Advertising: Employee Recruitment		
		0		FICA Taxes	285,978	Health Care Worker Background Check		
		0		Employee Health Insurance	110,290	(Indicate # of checks performed 82)	820	
		0		Employee Meals	38,402	Patient Background Checks	593 5,930	
		0		Illinois Municipal Retirement Fund (IMRF)*		Surety Bond	440	
		0		Dental/Life Insurance	3,494	ILL Health Care Association	3,594	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Relations	1,394	Chicago Title/Sec of State/Costco/ATS	803	
(List each licensed administrator separately.)			\$ 167,853	Misc Payroll Costs/401K Match	3,050			
B. Administrative - Other				Employee Drug Tests//Vaccinations	7,258	Related party - AMS	1,039	
Description			Amount	Tuition Reimbursement	6,797	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 559,303	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,626	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Alden Management Services	Consulting Fees		\$ 939,235			\$	Out-of-State Travel	\$
Virchow Krause/BDO Seidman	Accounting Fees		11,543					
Ava P. Daley/KPMG	Accounting Fees		233					
Kenneth J Fisch	Legal Fees: Non-Collections		160				In-State Travel	
AMS (Eliminated)	Allocated Legal Fees		36,000					
Linda Roberts & Assoc	Food Service Audit		900					
Medi.Com	Billing Consultants		212				Related party - AMS	1,651
Pathway-Reclass to Nursing	Clinical Consulting		9,839				Seminar Expense	
Kenneth J Fisch	Legal Fees: Collections		28,032				Leadership/Deming Training	1,000
							HIN Sem/SONMIX Training	461
							IL Council Seminar/IHCA Conv/NATINV	752
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,026,154			TOTAL		\$ 3,864
				* Attach copy of IMRF notifications		**See instructions.		

Facility Name & ID Number Alden - North Shore Rehabilitation and Health Care Center, Inc.	STATE OF ILLINOIS # 004-2028	Report Period Beginning: 1/1/2011	Ending: 12/31/2011
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. IHCA=\$ 3,593.52 IL Assoc. of HC=\$0

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,740 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,918
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 38,402 Has any meal income been offset against related costs? None Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 0
 d. Have vehicle usage logs been maintained? No
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
 Attach invoices and a summary of services for all architect and appraisal fees